SOUTHERN ILLINOIS HEALTH INFORMATION EXCHANGE

OPT-OUT FORM

A Health Information Exchange (HIE) is a way of sharing your health information among participating doctor's offices, hospitals, and other care providers through secure, electronic means. The purpose of the HIE is to give participating providers faster access to your health information that will facilitate safer, more timely, and efficient patient-centered care. When you opt*-out of participation in the HIE doctors, nurses and other healthcare providers will not be able to obtain and use your health information in the HIE when providing treatment to you.

**"Opt" means you making a "choice"*

I hereby acknowledge and agree as follows:

1. I understand that by submitting this HIE Opt-Out Request Form my health information in the SI HIE system will not be viewable by health care providers (including emergency room physicians).
2. I understand my opt-out selection will remain in effect unless I change it in writing. I am free to opt back in at any time and can do so by completing the SI HIE Opt-In Request Form that can be obtained on www.sih.net website or by contacting the Privacy Officer at the address at the bottom of this form.
3. I understand any information that is disclosed via the SI HIE prior to the date SIH received this form, cannot be taken back and will remain with providers who accessed such information before this Opt-Out went into effect.
4. I understand this request only applies to sharing my health information through the SI HIE system. I recognize that when I see a healthcare provider for treatment that provider may request and receive my health information from other providers using other methods permitted by law, such as fax or mail.

Reason for opting out (Optional): _____
_____

First Name:	Last Name:	Middle Name/Initial:
Date of Birth:	Last 4 Digits of SS#	Sex (M/F):
Mailing Address:		
City:		State:
Primary Phone #		Zip:

_____ _____

Signature of Patient (or Authorized Representative) Date Signed

If under 18 years, signature of parent or guardian

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as:

(CHECK ONE) ☐ Parent ☐ Legal Guardian ☐ Other (Specify Relationship) _____

Mail this completed form to the Privacy Officer, Southern Illinois Healthcare, 1239 E Main, Carbondale, IL 62901 or by email to sihie@sih.net.